BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: DOUGLAS T. Claimant, vs. CENTRAL VALLEY REGIONAL CENTER, Service Agency.	OAH No. N 2006060581

DECISION

Administrative Law Judge Robert Walker, State of California, Office of Administrative Hearings, heard this matter in Fresno, California, on July 31, 2006.

Shelley Celaya, Client Appeals Specialist, represented Central Valley Regional Center.

Jacqueline F., claimant's sister, represented the claimant, Douglas T.

SUMMARY AND ISSUES

Claimant is a regional center consumer. Regional center reassessed him and concluded that, in fact, he is not eligible for regional center services. Regional center sent claimant a notice of proposed action in which it advised him that it was going to close his case, that is, remove him from the roll of regional center consumers. Claimant appeals.

Is claimant eligible for regional center services? That is the ultimate issue.

Claimant contends that he comes within the, so called, fifth category of eligibility. That is, he contends that he has a disabling condition that is closely related to mental retardation or that he has a disabling condition that requires treatment similar to that required

for individuals with mental retardation.[1] The qualifying conditions are discrete. One can qualify for services if he or she has a disabling condition that is closely related to mental retardation. And one can qualify if he or she has a disabling condition that requires treatment similar to that required for individuals with mental retardation.

Intermediate issues include the following:

1. Does claimant have a disabling condition?

2. Did claimant's disability originate before he attained age 18?

3. Can claimant's disability be expected to continue indefinitely?

4. Does claimant's disability constitute a substantial disability for him?

5. Is claimant's disabling condition one that is closely related to mental retardation?

6. Is claimant's disabling condition one that requires treatment similar to that required for individuals with mental retardation?

7. Is claimant's condition solely physical in nature?

8. Is claimant's condition solely a psychiatric disorder?

9. Is claimant's condition solely a learning disability?[2]

FACTUAL FINDINGS

BACKGROUND

1. Claimant, Douglas T., was born on April 17, 1948. He is 58 years old.

2. Claimant's mother died in 2003. Before she died, claimant had always lived with her except for a period in 1968-69 when claimant served in the army. Claimant was extremely upset over his mother's death.

[1] The, so called, fifth category is found in Welfare and Institutions Code, section 4512, subdivision (a).

[2] The first seven of these issues are derived from Welfare and Institutions Code, section 4512, subdivision (a). Issues numbers eight and nine are derived from the California Code of Regulations, title 17, section 54000, subdivision (c).

3. Claimant's mother had never wanted any mental health services for claimant. And because of her insistence, claimant's brother and two sisters had not arranged for claimant to apply for mental health services.

4. After the mother died, claimant's siblings urged him to apply for mental health services from the Veterans Administration and urged him to apply for regional center services, and he did apply.

5. Claimant now receives medical and mental health services from the Veterans Administration.

THE 2004 DETERMINATION THAT CLAIMANT IS ELIGIBLE FOR LANTERMAN ACT SERVICES

6. On January 17, 2004, Lance A. Portnoff, Ph.D., administered the Wechsler Adult Intelligence Scale – 3rd edition (WAIS – III) and the Wechsler Memory Scale -Revised (WMS – R) to claimant. On the WAIS – III, claimant achieved a full-scale IQ of 72, which is within the range of borderline intellectual functioning. The full-scale score of 72 was derived from a composite score of 78 on the verbal scale and a composite score of 70 on the performance scale. There was a significant discrepancy between the verbal comprehension score of 88 and the perceptual organization score of 76. Dr. Portnoff made the following diagnoses:

> Axis I: "Personality Change Due to Cognitive Disorder, NOS, combined Disinhibited-Aggressive Type.
>
> Cognitive Disorder, NOS, with Unspecified Auditory Hallucinations.
>
> Learning Disorder, NOS, Mild.
>
> Polysubstance Abuse, in Reported Full Remission.
>
> Axis II: Borderline Intellectual Functioning.
>
> Axis III: By history: SP-cardiac arrest. Probable mild neurobehavioral syndrome – etiology unknown.
>
> Axis V: Global Assessment of Functioning (GAF): 55 (moderate impairment).

7. Regional center asked Michael S. Kesselman, Ph.D., a clinical psychologist to assess claimant's adaptive functioning. Dr. Kesselman reviewed the results of Dr. Portnoff's testing and wrote a report dated March 31, 2004. He did not test or meet with claimant. In Dr. Kesselman's report, he wrote that he used the Vineland Adaptive Behavior Scale. He

wrote, also, that he had a telephone conversation with one of claimant's sisters, Jackie F. (Jackie). One cannot tell from the report who the source of the information was for the Vineland. Perhaps it was Jackie. Dr. Kesselman reported the following history:

> Douglas presented an education history in which he was in mainstream classes throughout elementary and high school. He did have some difficulty with math. He indicated that he was depressed on and off all his life. He attempted suicide as a teenager. He has problems with temper and explodes at perceived injustice. At times, he may yell and scream at cars passing by for hours. He does drive and is able to live independently through managing a checking account. He last worked as a security guard and had been fired for exploding on the job.

8. The following is a paraphrased summary of what Jackie told Dr. Kesselman. Claimant has always been described a slow. He functions as a 12 year old. He was always several grades behind in school. Claimant's statements concerning his abilities are unreliable and exaggerated. For example, he claims that he can manage his own finances, but he cannot. He, however, can do basic cooking.

9. Dr. Kesselman wrote that Jackie's statements regarding claimant were inconsistent with Dr. Portnoff's examination.

10. Dr. Kesselman concluded that claimant's communication skills were those of someone nine years old, that his daily living skills were those of someone 10 years old, and that his socialization skills were those of someone 12 years old.

11. Dr. Kesselman wrote that, because he did not meet with Douglas and because he spoke with Jackie only by telephone, he would be hesitant to give a diagnosis. The following is a paraphrased summary of part of Dr. Kesselman's conclusions: The results from Dr. Portnoff's testing suggest borderline intelligence. Claimant's inability to keep a job seems to be due to personality rather than cognitive deficits. Claimant may have had brain damage as a child. He does have deficits that are consistent with possible organic impairment. This might allow regional center eligibility under the fifth category. Also, he might need services similar to those required by individuals who are mentally retarded. Everyone reports that claimant cannot hold a job, which suggests a deficit in his capacity for economic self-sufficiency.

12. After receiving Dr. Kesselman's report, regional center assessed claimant and concluded that he had a disabling condition that is closely related to mental retardation or a disabling condition that requires treatment similar to that required for individuals with mental retardation. The assessment team concluded that claimant's condition constituted a substantial disability for him because he had significant functional limitations in four areas –

communication skills, learning, self-direction, and economic self-sufficiency. In an April 28, 2004, entry in a diagnostic sheet, one of the members of the assessment team wrote, "Re-evaluate IQ & adaptive functioning in 2 years, spring of '06."

13. Claimant, in spite of having been found eligible for regional center services, made little use of those services. He did receive some independent living services, but those stopped sometime before September of 2005. Claimant's siblings, however, have urged him to use regional center services, particularly to attend a day program. And in early 2006, regional center identified a day program for claimant, and he agreed to attend. Before he began attending, however, regional center reassessed his eligibility, and he did not start attending.

NEUROPSYCHOLOGICAL EVALUATION IN 2005

14. On May 5, 2005, Matthew A. Battista, Ph.D., a clinical neuropsychologist, administered a battery of tests to claimant and wrote a report. One of the tests Dr. Battista administered was the WAIS – III. Dr. Battista wrote:

> [Claimant] . . . obtained a Verbal IQ of 86, a Performance IQ of 72, and a Full Scale IQ of 77. The Verbal Comprehension Index was 96, Perceptual Organization Index was 72, Working Memory Index was 75, and Processing Speed Index was 68. Among the verbal subtests, Vocabulary and Information were relative strengths . . . . Arithmetic was the lowest score . . . . Within the Performance subtests, there was no significant inter-test scatter; however, it was clear that [claimant] . . . had most difficulties with subtests requiring speed and visual-spatial organization. Overall, results from the WAIS – III suggest borderline to low average intelligence with verbal comprehension skills being significantly superior to working memory, nonverbal reasoning, and speeded mental abilities.

REGIONAL CENTER'S REASSESSMENT OF CLAIMANT'S ELIGIBILITY

15. In early 2006, regional center reassessed claimant's eligibility. As part of that reassessment regional center asked Future Transitions, Inc., of Lancaster, California, to evaluate claimant's adaptive functioning. On February 28, 2006, Yvette Fisher of Future Transitions did an evaluation. She visited claimant in his home and interviewed and observed him. She also spoke with claimant's regional center service coordinator, Christina Scott. Ms. Fisher used a charting tool with 158 items on it -- items such as "greets new people appropriately," "can revise plan to achieve goals," "keeps bills stored together," "writes a shopping list," and "understands the basic food groups." Ms. Fisher rated claimant on all but three of the items. She rated him "no" or "sometimes" on 13 items and "yes" on 142 items.

16. Jackie, claimant's sister testified that many of Ms. Fisher's "yes" ratings for claimant are incorrect. Jackie testified that Ms. Fisher's charting tool vastly overstates claimant's abilities, and Jackie testified as to particular items with which she is familiar.

17. There was no evidence as to Ms. Fisher's background or experience, and she did not testify.

18. Gail Lasker, Ph.D., Executive Director of Future Transitions, Inc., wrote a report and a service plan in which she gives her impressions and makes a recommendation. Her recommendation is as follows:

> This evaluator believes Douglas could benefit from in-home education training in the areas of money management, food and non-food shopping, meal preparation and family nutrition, and personal management of health. It is recommended that Douglas receive 12 hours per month of Independent Living Skills for a period of 6 months in order to meet the goals in his Individual Service Plan.

19. It is not clear whether Dr. Lasker met claimant. She, like Ms. Fisher, is identified in the report as an "evaluator." There was no evidence as to Dr. Lasker's experience, and she did not testify.

20. There was no evidence that Ms. Fisher's charting tool is a standard measure of adaptive functioning.

21. It is found that very little weight should be accorded this hearsay report.

22. On April 4, 2006, regional center concluded that, in fact, claimant is not eligible for regional center services. Regional center sent claimant a May 3, 2006, notice of proposed action in which it advised him that it was going to close his case, that is, remove him from the roll of regional center consumers. Claimant appealed.

23. Because this is a case in which regional center seeks to take away claimant's eligibility for services, regional center has the burden of proof.

ONE EXPERT TESTIFIED REGARDING CLAIMANT'S CONDITION

24. Carol Sharp, Ph.D., is a staff psychologist with the regional center. She was the only expert who testified at the hearing in this matter. Dr. Sharp is a clinical psychologist with a specialty in child psychology. She has been with the regional center for over two years and spends a substantial amount of time assessing applicants and determining whether they are developmentally disabled.

25. Dr. Sharp noted that, in diagnosing mental retardation, one should use a standardized IQ test and a standard measure of adaptive functioning.

26. Dr. Sharp testified that IQ subtest scores with significant discrepancy or scatter tend to indicate a learning disability rather than mental retardation.

27. Dr. Sharp referred to scores claimant obtained on the WAIS – III that Dr. Battista administered – the verbal IQ of 86 and the performance IQ of 72 – and noted that this is a substantial discrepancy. In defining the term "general intellectual functioning," The American Psychiatric Association's Diagnostic and Statistical Manual, fourth edition, Text Revision, (DSM IV TR) addresses the circumstance in which there is a significant discrepancy – or scatter – in scores. The DSM IV TR says that, when there is significant scatter, the mathematically derived IQ may not accurately reflect the person's abilities and may be misleading. The DSM IV TR says:

> When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.[3]

28. Dr. Sharp referred to averaging in such circumstances as producing an artifact of statistical averaging. She testified that, thus, the full scale IQ of 77 that Dr. Batista calculated for claimant is not trustworthy.

29. Dr. Sharp testified that claimant's overall scores and his relatively high verbal comprehension index of 96 shows that he is not mentally retarded.

30. Dr. Sharp did not testify that a person with claimant's IQ scores could not qualify under the fifth category. Rather, she testified that a person with claimant's IQ scores could not qualify under the fifth category unless he or she had very low adaptive functioning.

31. Dr. Sharp referred to the Future Transitions report and said that claimant does not have very low adaptive functioning. Also, she stressed her opinion that the deficits in adaptive functioning claimant does have are caused by a psychiatric disorder and not by low intellectual functioning. But Dr. Sharp did not explain how one can determine whether a deficit in adaptive functioning is being caused by a psychiatric condition rather than by cognitive deficits. Also, she did not explain why deficits in adaptive functioning caused by a psychiatric condition should be excluded from consideration.

[3] DSM IV TR, p. 42.

CLAIMANT'S SISTER'S TESTIMONY

32. Jackie, claimant's sister, testified that nothing had changed since regional center originally assessed claimant, other than the fact that he has "gotten worse."

33. The following is a paraphrased summary of Jackie's testimony: Claimant first came to the regional center just after our mother died. Claimant had lived with her. Claimant makes very unreliable and incorrect statements about himself and his abilities. He claims to have served in the military. In fact, he was kicked out of boot camp. Claimant claims to have taken care of our mother, but he never took care of her. He claims to play golf, but he does not play golf. He claims that he can manage his money and that he writes checks, but neither of those things is true.

WHAT IS MENTAL RETARDATION?

34. In determining whether claimant has a disabling condition that is closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation, it is helpful to know something about mental retardation.

35. The DSM IV TR identifies three criteria – one "essential" criterion and two other criteria -- used in diagnosing mental retardation. The "essential" criterion is "significantly subaverage general intellectual functioning." A second criterion is that the subaverage general intellectual functioning must be "accompanied by significant limitations in adaptive functioning . . . ." And the third and final criterion is that "the onset must occur before age 18 years."[4]

GENERAL INTELLECTUAL FUNCTIONING

36. The DSM IV TR provides that:

> General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children-Revised, Stanford-Binet, Kaufmann Assessment battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus it is possible to

[4] DSM IV TR, p. 41.

> diagnose mental retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior . . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.[5]

37. The DSM IV TR also provides for distinguishing among levels of intellectual impairment depending on the degree of severity of a party's mental retardation. The levels are as follows:

> Mild … IQ … 50-55 to approximately 70
> Moderate … IQ … 35-14 to 50-55
> Severe … IQ … 20-25 to 35-40
> Profound … IQ … below 20 or 25[6]

38. According to the DSM IV TR, people with mild mental retardation:

> typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth grade level.[7]

39. A person with and IQ between 71 and 84, if not mentally retarded, is considered to be of borderline intellectual functioning. The DSM IV TR provides:

> Borderline Intellectual functioning . . . describes an IQ range that is higher than that for Mental Retardation (generally 71 – 84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental

[5] *Id*. at pp. 41 – 42.

[6] *Id*. at p. 42

[7] *Id*. at p. 43.

> Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.[8]

CLAIMANT'S LEVEL OF COGNITIVE FUNCTIONING

40. What is the level of claimant's ability to acquire knowledge and make judgments? Does claimant's condition involve something that resembles the essential criterion for diagnosing mental retardation? That is, does it involve something that resembles significantly subaverage general intellectual functioning?

41. As noted above, Dr. Portnoff, in 2004, diagnosed borderline intellectual functioning, and Dr. Battista, in 2005, concluded that, overall, the "results from the WAIS – III suggest borderline to low average intelligence with verbal comprehension skills being significantly superior to working memory, nonverbal reasoning, and speeded mental abilities."

ADAPTIVE FUNCTIONING

42. The DSM IV TR criterion regarding limitations in adaptive functioning concerns "significant limitations . . . in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety."[9]

> Impairments in adaptive functioning rather than low IQ are usually the presenting symptoms in individuals with Mental Retardation. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. *Adaptive functioning may be influenced by* various factors, including education, motivation, personality characteristics, social and vocational opportunities, and *the mental disorders and general medical conditions that may coexist with Mental Retardation.* Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.[10] (Italics added.)

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[8] *Id.* at p. 48.

[9] *Id.* at p. 41.

[10] *Id*. at p. 42.

43. The DSM IV TR recommends that one gather evidence regarding adaptive functioning from one or more reliable independent sources e.g. teacher evaluation and educational, developmental, and medical history.

> Several scales have also been designed to measure adaptive functioning or behavior (e.g. the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale). These scales generally provide a clinical cutoff score that is a composite of performance in a number of adaptive skill domains.[11]

CLAIMANT'S LEVEL OF ADAPTIVE FUNCTIONING

44. The record in this proceeding, unfortunately, is rather unsatisfactory regarding claimant's adaptive functioning. The Vineland Adaptive Behavior Scale that Dr. Kesselman completed in March of 2004 appears to have been based on information Jackie gave him in a telephone conversation.

45. And there is insufficient evidence to support a conclusion that the Future Transitions report is reliable. As noted above, Jackie testified that Ms. Fisher's charting tool vastly overstates claimant's abilities. There was no evidence as to Ms. Fisher's background or experience and no evidence as to Dr. Lasker's experience, and neither of them testified. And there was no evidence that Ms. Fisher's charting tool is a standard measure of adaptive functioning.

46. Moreover, Dr. Lasker did not conclude that claimant had no deficits in adaptive functioning. She recommended that he have in-home education training in the areas of money management, food and non-food shopping, meal preparation and family nutrition, and personal management of health.

LEGAL CONCLUSIONS

THE LANTERMAN ACT

1. The Lanterman Act is an entitlement act. People who are eligible under it are entitled to services and supports.[12]

> The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled

[11] *Ibid.*

[12] *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.

> persons and their dislocation from family and community (citations) and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community (citations). [13]

2. The act is a remedial statute and, as such, must be interpreted broadly.[14]

3. A developmental disability is a "disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual." The term includes mental retardation, cerebral palsy, epilepsy, autism, and what is commonly referred to as the "fifth category."[15] The fifth category includes "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation."[16]

4. Thus, individuals whose IQ scores do not fall squarely within the range of mental retardation can be eligible under the fifth category.

ARCA GUIDELINES FOR DETERMINING FIFTH CATEGORY ELIGIBILITY

5. The Association of Regional Center Agencies (ARCA) has promulgated guidelines for determining fifth category eligibility. The guidelines provide, in part, as follows:

> Mental retardation is defined in the DSM-IV as "significant subaverage general intellectual functioning . . . that is accompanied by significant limitations in adaptive functioning . . . ." General intellectual functioning is measured by assessment with one or more standardized tests. Significantly sub-average intellectual functioning is defined as an intelligence quotient (IQ) of 70 or below. An individual can be considered to be functioning in a manner that is similar to a person with mental retardation if the general intellectual functioning is in the low borderline range of intelligence (IQ scores ranging from 70-74)

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[13] *Id.* at p. 388.

[14] California State Restaurant Association v. Whitlow (1976) 58 Cal.App.3d 340, 347.

[15] Welf. & Inst. Code, § 4512, subd. (a).

[16] *Ibid.*

. . .

> In addition to sub-average intellectual functioning the person also must demonstrate significant deficits in *Adaptive* skills, including, but not limited to communication, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Factors that the eligibility team should consider include:
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> 1. Adaptive behavior deficits as established on the basis of clinical judgments supplemented by formal Adaptive Behavior Scales (e.g., Vineland ABS, AAMR-ABS) when necessary.
>
> 2. Adaptive deficits are skill deficits related to intellectual limitations that are expressed by an inability to perform essential tasks within adaptive domains or by an inability to perform those tasks with adequate judgment.
>
> *3. Skill deficits are not performance deficits due to factors such as* physical limitations, *psychiatric conditions*, socio-cultural deprivation, poor motivation, substance abuse, or limited experience. (Italics added.)

6. The ARCA guidelines for determining fifth category eligibility are similar to the DSM IV TR diagnostic features regarding mental retardation. There are, however, at least two respects in which the ARCA guidelines differ from the DSM IV TR diagnostic features, and those two respects concern adaptive functioning. The DSM IV TR provides that, in order to diagnose mental retardation, one must find "significant limitations . . . in at least two . . . skill areas. The ARCA guidelines concerning fifth category do not specify a particular number of skill areas in which one must find limitations. There is an additional requirement for establishing that one is developmentally disabled, however. One must prove that one's disability constitutes a substantial disability, and the Lanterman Act defines substantial disability as significant functional limitations in at least three areas of major life activity.[17] The definition then lists areas of major life activity. The list is not identical to the DSM IV TR list of functional limitation skill areas, but the two lists address many of the same things. And the ARCA list of skill areas is almost identical to the list in the Lanterman Act definition of substantial disability. Thus, in spite of the fact that the ARCA guidelines do not specify how many adaptive skills must be deficient, one could not be found to be developmentally disabled under any category without demonstrating deficits in at least three areas of major life activity.

[17] Welf. & Inst. Code, § 4512, subd. (l).

7. A second, and more significant, respect in which the ARCA guidelines differ from the DSM IV TR diagnostic features is that the guidelines rule out consideration of deficits in adaptive skills caused by psychiatric conditions. As noted above, the DSM IV TR provides that in order to diagnose mental retardation, a person's significantly subaverage general intellectual functioning must be, "*accompanied by* significant limitations in adaptive functioning . . . ."[18] (Italics added.)

And the DSM IV TR further provides that:

> *Adaptive functioning may be influenced by* various factors, including education, motivation, personality characteristics, social and vocational opportunities, and *the mental disorders and general medical conditions that may coexist with Mental Retardation.* [19] (Italics added.)

8. Thus, the DSM IV TR does not suggest that one can or should distinguish between impairments in adaptive functioning that are caused by cognitive deficits and those that are cause by the mental disorders that may coexist with mental retardation.

9. The ARCA guidelines do not explain how one can determine whether impairment in adaptive functioning is being caused by a psychiatric condition rather than by a cognitive deficit. Neither do the guidelines explain why they deviate from the DSM IV TR in ruling out consideration of impairments in adaptive functioning caused by a psychiatric condition if the psychiatric condition coexists with mental retardation. One must admit that there is something of a chicken and egg problem here, but the guidelines differ from the DSM IV TR without so much as noting the difference.

MASON V. OFFICE OF ADMINISTRATIVE HEARINGS

10. The ARCA guidelines refer to the 2001 case *Mason v. Office of Administrative Hearings*.[20] In *Mason*, the district court held that a claimant was eligible under the fifth category, and the regional center appealed. That is, the district court held that the claimant had a disabling condition that is closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation. On appeal, the regional center contended that the fifth category was void because the statutory language was impermissibly vague and, therefore, failed to satisfy constitutional due process requirements. The court of appeal held that, although the statutory language was somewhat unclear, "the

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[18] *Id*. at p. 41.

[19] *Id*. at p. 42.

[20] *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119.

statute and its implementing regulations, when considered as a whole, are sufficiently clear so as to avoid a constitutional vagueness challenge."[21]

11. The court said, "In determining whether section 4512(a)'s fifth category of developmental disability is impermissibly vague, we must take into account the Legislature's intent to defer to the . . . [Department of Developmental Services] and . . . [regional center] implementation of the Lanterman Act."[22] In support of the proposition that the Legislature intended to defer to the Department of Developmental Services and regional center implementation of the act, the court cited the act at sections 4640 and 4643. Section 4640 provides that, in order to ensure uniformity in the application of definitions of developmental disability, the director of disability services shall issue regulations. That section further provides, in issuing regulations, the director shall invite and consider the views of regional center contracting agencies. Section 4643 sets limitations on the time a regional center may take to assess someone who applies for an eligibility determination. That section also provides that, in doing an assessment, a regional center may review data, provide tests and evaluations, and summarize developmental levels and service needs. Section 4643, subdivision (b) provides:

> In determining if an individual meets the definition of developmental disability . . . the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests and other tests or evaluations that have been performed by, and are available from, other sources.

12. The court said, further, "Here, the Lanterman Act and implementing regulations clearly defer to the expertise of the . . . [Department of Developmental Services] and . . . [regional center] professionals determination as to whether an individual is developmentally disabled. General as well as specific guidelines are provided in the Lanterman Act and regulations to assist such . . . [regional center] professionals in making this difficult, complex determination. Some degree of generality and, hence, vagueness is thus tolerable."[23]

THE ARCA GUIDELINES ARE NOT REGULATIONS AND NOT ENTITLED TO THE WEIGHT ONE WOULD GIVE A REGULATION

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[21] Id. at p. 1123.

[22] Id. at p. 1127.

[23] Id. at p. 1129.

13. The ARCA guidelines have not gone through the formal scrutiny that provisions must go through to become a regulation.

14. And *Mason* does not stand for the proposition that guidelines adopted by a professional association of regional centers are entitled to some special deference. The issue before the *Mason* court was whether the regional center was correct in its contention that part of the Lanterman Act should be found to be void for vagueness. That is very different from the question of whether some special deference should be paid to guidelines adopted by a professional association. Moreover, the sections of the Lanterman Act the court cites for the proposition that the Legislature intended to defer to regional center implementation of the act, do not suggest that some special deference should be paid to guidelines adopted by a professional association. Section 4640 concerns the formal adoption of regulations, and section 4643 specifies the sort of information a regional center may consider in determining whether an applicant is developmentally disabled.

15. Regional center offered no evidence that one can or should distinguish between impairments in adaptive functioning that are caused by cognitive deficits and those that are caused by the mental disorders that may coexist with mental retardation.

16. Regional center offered no evidence as to why the ARCA guidelines deviate from the DSM IV TR in ruling out consideration of impairments in adaptive functioning caused by a psychiatric condition if the psychiatric condition coexists with mental retardation. It is true, of course, that the DSM IV TR concerns diagnosing mental retardation while the ARCA guidelines concern determining whether someone is developmentally disabled. But the ARCA guidelines begin by referring to the DSM IV definition of mental retardation, and without some explanation or justification for the deviation regarding impairments that are caused by mental disorders, that deviation should not be followed.

17. There is no evidence in this case that supports the ARCA guideline that rules out consideration of deficits in adaptive skills caused by psychiatric conditions.

REGIONAL CENTER FAILED TO PROVE THAT CLAIMANT IS NOT ELIGIBLE UNDER THE FIFTH CATEGORY

18. There is no question that, if this were a case in which claimant was applying for eligibility, the evidence would require a determination that he had failed to sustain his burden of proof. But claimant is a regional center consumer. In 2004, regional center assessed him and found him to be eligible for Lanterman Act services. Regional center now seeks to reverse that decision and take away claimant's eligibility. In order to do that, regional center must prove that claimant is not developmentally disabled. Claimant need not prove that he is eligible. Regional center must prove that he is not. And regional center failed to do that.

19. As noted above, Dr. Sharp referred to scores claimant obtained on the WAIS – III that Dr. Battista administered and said that there was a substantial discrepancy. The DSM IV TR says, "When there is significant scatter in the subtest scores, the *profile of strengths and weaknesses*, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities." (Italics added.) If regional center presented a profile of claimant's strengths and weaknesses, it is not clear what the profile was. Perhaps regional center intended the Future Transitions report to be a profile of claimant's strengths and weaknesses, but for reasons stated above, it is determined that very little weight should be accorded that hearsay document.

20. Dr. Sharp testified that a person with claimant's IQ scores cannot qualify under the fifth category unless he or she has very low adaptive functioning. Dr. Sharp referred to the Future Transitions report and said that claimant does not have very low adaptive functioning. But in 2004 a regional center assessment team concluded that claimant's condition constituted a substantial disability for him because he had significant functional limitations in four areas – communication skills, learning, self-direction, and economic self-sufficiency. Dr. Sharp has not done an assessment of claimant's adaptive functioning, and the evidence in this case fails to show that the Future Transitions report is the sort of thing on which one should rely. And Dr. Sharp did not explain why she relied on it except to say that she understood that the information in the charting tool was based on observations.

21. Dr. Sharp stressed her opinion that the deficits in adaptive functioning that claimant does have are caused by a psychiatric disorder and not by low intellectual functioning. But Dr. Sharp did not explain how one can determine whether a limitation in adaptive functioning is being caused by a psychiatric condition rather than by cognitive deficits. Also, she did not explain why impairments in adaptive functioning caused by a psychiatric condition should be excluded from consideration. And as noted above, there is insufficient reason to follow the ARCA guideline that rules out consideration of deficits in adaptive skills caused by psychiatric conditions.

IF A REGIONAL CENTER REASSESSES WHETHER A CONSUMER HAS A SUBSTANTIAL DISABILITY, THE REGIONAL CENTER MUST USE THE SAME CRITERIA UNDER WHICH THE CONSUMER ORIGINALLY WAS MADE ELIGIBLE

22. The Lanterman Act defines "substantial disability" as follows:

> "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: (1) Self-care. (2) Receptive and expressive language. (3) Learning. (4) Mobility. (5) Self-

> direction. (6) Capacity for independent living. (7) Economic self–sufficiency.[24]

23. The Lanterman Act further provides that, "Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible."[25]

24. The California Code of Regulations defines "substantial handicap" as being similar to the Lanterman Act definition of substantial disability. The definition of substantial handicap is as follows:

> "Substantial handicap" means a condition which results in major impairment of cognitive and/or social functioning. Moreover, a substantial handicap represents a condition of sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential.[26]
>
> Since an individual's cognitive and/or social functioning are many-faceted, the existence of a major impairment shall be determined through an assessment which shall address aspects of functioning including, but not limited to: (1) Communication skills; (2) Learning; (3) Self-care; (4) Mobility; (5) Self-direction; (6) Capacity for independent living; [and] (7) Economic self-sufficiency.[27]

25. In order to be eligible for Lanterman Act services, one must have a disability that is caused by one of the five disability categories. Also, the disability must constitute a substantial disability for the individual. When the disability category is cerebral palsy or epilepsy, for example, it is clear that the assessment of whether the disability constitutes a substantial disability involves a discrete investigation. When the disability category is mental retardation or the fifth category, however, there often appears to be a good deal of overlap between the question of whether an applicant has a disability and the question of whether, if he or she does, it is a substantial disability for that individual.

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[24] Welf. & Inst. Code, § 4512, subd. (l).

[25] *Ibid.*

[26] Cal. Code Regs., tit. 17, § 54001, subd. (a).

[27] *Id*. at subd. (b).

26. As noted above, when the regional center originally determined that claimant was eligible, the assessment team concluded that claimant's condition constituted a substantial disability for him because he had significant functional limitations in four areas – communication skills, learning, self-direction, and economic self-sufficiency.

27. It is not clear in this case that regional center reassessed the issue of whether claimant's disability constitutes a substantial disability for him. It may be that regional center simply decided that claimant has no disability and that; therefore, there was no reason to go to the next step of assessing substantiality.

28. If regional center did reassessed the issue of whether claimant's disability constitutes a substantial disability for him, it failed to prove that it complied with the requirement that it utilize the same criteria under which the individual was originally made eligible.

29. In any event, it is determined that regional center failed to satisfy the burden of proving that claimant is not developmentally disabled.

ORDER

The appeal of claimant, Douglas T., from the service agency's notice of proposed action is granted.

DATED:

_____
ROBERT WALKER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.